

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u>	
TOWN <u>80</u>		LENGTH OF STAY (in this place) <u>10 minutes</u>		STREET ADDRESS (If rural give location) <u>27</u>		ADDRESS <u>09X-27</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Thurston L. Batson</u>				<u>5/20 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH: <u>Oct 25-1917</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>factory</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Henry Batson</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> If Yes, give year of entry of service <u>WW II</u>				16. SOCIAL SECURITY NO. <u>221-05-6319</u>		17. INFORMANT & ADDRESS: <u>Henrietta E. Batson (sister-in-law)</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pneumonia</u>							
ANTECEDENT CAUSE (S) <u>Chronic bronchopneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Parkinson's disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>1955</u> , that I last saw the deceased alive on <u>5-21-55</u> , and that death occurred at <u>4:05</u> P. M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>23 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>				DATE THEREOF <u>5-24-55</u>			
NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>				LOCATION (City, town, or county) (State) <u>near Federalburg Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-21-55</u>				REGISTRAR'S SIGNATURE <u>N.H. Neerue</u>			
24. FUNERAL DIRECTOR <u>J. Transp. Don Federalburg Md</u>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 27 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04976

4974

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 TOWN <i>Easton</i>		2 days		<i>Preston Md.</i> 05X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <i>Memorial Hospital</i>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
<i>Lidia</i>		<i>Cannon</i>					
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>Female</i>		<i>White</i>		<i>Widowed April 16 - 1879</i>		<i>76 yrs.</i>	
						9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>N.W.</i>				<i>USA.</i>		<i>USA.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John Lippin</i>				<i>Elizabeth Anthony</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>Y</i>							
17. INFORMANT & ADDRESS:							
<i>Mary J. Adams - (Daughter)</i>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
(A) DUE TO							
<i>Cardiac failure</i>							
ANTECEDENT CAUSE (S):							
(B) DUE TO							
<i>Coronary occlusion</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <i>Advanced arteriosclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<i>2</i>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/24</i> , 19 <i>55</i> , to <i>5/26</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5/25</i> , 19 <i>55</i> , and that death occurred at <i>4:56</i> P.M., from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<i>Edith M. ...</i>		<i>Cannon</i>		<i>Preston Md.</i>		<i>27 May 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>5/31/55</i>		<i>West Preston</i>		<i>Preston Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5/27/55</i>		<i>N. H. Neuman</i>		<i>James B. ...</i>		<i>Preston, Md.</i>	

RECEIVED

JUN 2 1955

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 290....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>		STATE <u>Md.</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Easton - rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Easton (rural)</u>	
LENGTH OF STAY (in this place) <u>13 yrs</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Clara</u> <u>Ella</u> <u>Carmine</u>		OF DEATH: <u>May</u> <u>17</u> <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>white</u>	<u>widowed</u>	<u>Aug. 14, 1870</u>
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY:	
<u>84 yrs.</u>		<u>housekeeper</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Md.</u>		<u>U. S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Andrew Collison</u>		<u>unknown Willoughby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>9</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Malcolm Carmine</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pellagra</u>			<u>yes</u>
ANTECEDENT CAUSE (B) <u>Avitaminosis</u>			<u>yes</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>In another</u>			<u>yes</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-1</u> , 19 <u>46</u> , to <u>5-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Ch. F. Buell</u>		DATE SIGNED <u>5-18-55</u>	
ADDRESS <u>Easton Md</u>		M. D. <u>Easton Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
<u>burial</u>		<u>Maurice E. Newnam &amp; Son Easton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/18/55</u>		REGISTRAR'S SIGNATURE <u>H. H. Neeress</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



ACCEPTANCE  
BOARD  
CIVIL RIGHTS

BUREAU V. S.

MAY 24 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4975 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04978  
CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Salisbury</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>40 Easton</i>	LENGTH OF STAY (In this place) <i>1 da 11 hrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Denton</i>	<i>05X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>80 Easton Memorial Hosp.</i>		STREET ADDRESS (If rural give location) ✓	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Leonard</i>	(Middle)	(Last) <i>Crew</i>	OF DEATH: <i>5 31 1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>Feb 11, 1887</i>
9. AGE last birthday <i>69</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Caroline Poultry Plant</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>Edward Crew</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Cannon</i>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mr. Berace L. Crew</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Pneumonia</i>			
ANTECEDENT CAUSE (S) DUE TO <i>Uremia</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Nephrosis, type undetermined</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>8/29</i> , 19 <i>55</i> , to <i>8/31</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/31</i> , 19 <i>55</i> , and that death occurred at <i>1:18 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Edith Schmidt</i>		DATE SIGNED <i>31/8/1955</i>	
M. D. <i>Cantor</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 3, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Denton</i>		LOCATION (City, town, or county) (State) <i>Denton Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-1-55</i>		REGISTRAR'S SIGNATURE <i>N.A. Neerich</i>	
24. FUNERAL DIRECTOR <i>J. Siegel</i>		ADDRESS <i>moreover Denton</i>	

BUREAU V. S.

JUN 7 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4989

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04979

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Md.		COUNTY Talbot	
CITY (If outside corporate limits, write TOWN and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write TOWN and give nearest town)		RURAL and give nearest town)	
X TOWN Oxford		life		TOWN Oxford		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				/			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) Frank		(Middle) Gilbert		(Last) Dobson		OF May 12, 19 55	
(Type or Print)							
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: Jan. 12, 1901	
						9. AGE last birthday 54 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ship carpenter at Wiley's Shipyard				10B. KIND OF BUSINESS OR INDUSTRY: Oxford, Md.			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME: Wm. Dobson				14. MOTHER'S MAIDEN NAME: Cordelia Dobbs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-07-7026		17. INFORMANT & ADDRESS: Mrs. Ione Dobson - Oxford, Md.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction				Sudden			
ANTECEDENT CAUSE (B) Arteriosclerotic Coronary Disease				1 year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1927 to 5/12/1955, that I last saw the deceased alive on 5/11/1955 and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE P. J. Cox				DATE SIGNED			
M. D. Easton Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 5-16-55		NAME OF CEMETERY OR CREMATORY Oxford Cemetery		LOCATION (City, town, or county) (State) Oxford, Talbot, Md.	
DATE REC'D BY LOCAL REGISTRAR 5-14-55		REGISTRAR'S SIGNATURE H. W. Newnam		24. FUNERAL DIRECTOR Maurice E. Newnam & Son		ADDRESS Easton, Md.	

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MAY 27 1955

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04980

4976

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 TOWN <u>Kastor</u>		14 days		Centreville		17X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 Memorial Hospital							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
William		James		Dorrell		May 24 1956	
(Type or Print)				Dorrell			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Married		Sept 14 1872	
						82 yrs.	
						9. AGE last birthday	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
Retired				Carpenter			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY:			
Maryland				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
MR. William Dorrell				Elizabeth Parrell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				216-07-7038			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
Mrs. Arquette Dorrell - wife				CENTREVILLE MD			
				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
591X							
IMMEDIATE CAUSE				(A) Due to			
ANTECEDENT CAUSE (S)				(B) Due to			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) Due to			
Bronchopneumonia, st.				Nephrosis, type undetermined.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
20. AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/10 1955, to 5/24 1955, that I last saw the deceased alive on 8/24/55, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)				DATE THEREOF			
Buried				May 27, 1955			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
Chestfield				Centreville, Maryland			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
5-25-55				N.A. Neuner			
24. FUNERAL DIRECTOR				ADDRESS			
Barton Bros. Centreville				Maryland			

BUREAU V. S.

JUN 2 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clinton</u>	STATE <u>Md.</u> COUNTY <u>Talbot</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clinton Md.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>	LENGTH OF STAY (in this place) <u>17 days</u>	STREET ADDRESS (If rural give location) <u>8 W + St.</u>	
3. NAME OF DECEASED: (First) <u>Betha</u> (Middle) <u>Lee</u> (Last) <u>Green</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>5/13/55</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 29, 1892</u>
9. AGE last birthday <u>63</u> yrs. <u>63</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel E. Patrick</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Susan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>4</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Im Ralph Green same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Laennec's Cirrhosis</u>			<u>3 yrs.</u>
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>Uremia</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			<u>2 weeks.</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>49</u> , to <u>5/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>55</u> , and that death occurred at <u>2:25 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Shepardo Keca Jr.</u>		DATE SIGNED <u>5/14/55</u>	
ADDRESS <u>Easton, Md.</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/15/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/14/55</u>		REGISTRAR'S SIGNATURE <u>N.H. Nevins</u>	
24. MEDICAL DIRECTOR <u>Charles L. ...</u>		ADDRESS <u>Clinton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 23 1955  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

04983

4973

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
TOWN <u>EASTON</u>		TOWN <u>EASTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NEEDWOOD AVE.</u>		STREET ADDRESS (If rural, give location) <u>NEEDWOOD AVE.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIAM</u> (Middle) <u>LUTHER</u> (Last) <u>HULL</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 21/1871</u>
9. AGE last birthday <u>83</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER-RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES HULL</u>		14. MOTHER'S MAIDEN NAME <u>SARA DUNNING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. William I. Norris, Jr. WINTON AVE. EASTON, MD.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>		15 yrs	
Antecedent cause(s) (b) <u>Arteriosclerosis, Renal</u>		-	
(c) <u>stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) <u>EASTON</u> (COUNTY) <u>TALBOT</u> (STATE) <u>MD.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-8-1955</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-8-1955</u> , 19 <u>40</u> , to <u>5-11-1955</u> , that I last saw the deceased alive on <u>5-8-1955</u> , 19 <u>51</u> , and that death occurred about <u>5-9 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. H. Norris</u> (Degree or title) <u>MD</u>		ADDRESS <u>Easton 2nd</u> DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>MAY 14/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL CEMETERY</u>		LOCATION (City, town, or county) <u>EASTON, MARYLAND</u> (State) <u>MD.</u>	
DATE REC'D BY LOCAL REG. <u>5/12/55</u>		24. FUNERAL DIRECTOR <u>W. Hampton Cawell</u> ADDRESS <u>EASTON, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04984

4990

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>BOZMAN</u>		<u>1-1/2</u>		OR TOWN <u>BOZMAN</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>RURAL</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Adam C. JONES</u>				OF DEATH: <u>MAY 28</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWER</u>	<u>MAY 24, 1880</u>	<u>75</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HICKSTER</u>				<u>GENERAL</u>		<u>BOZMAN MD</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>JAMES JONES</u>				<u>ELIZABETH A. JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NONE</u> <u>NONE</u>				<u>NONE</u>		<u>Samuel W. Bridger</u> <u>3127 Phelps Lane Balto-Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
42011 IMMEDIATE CAUSE						4 hrs	
(A) <u>Myocardial Infarction</u> DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) <u>arteriosclerotic C.V.D.</u> DUE TO	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>cardiac failure - chronic</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0 -</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-1</u> 19 <u>55</u> to <u>5-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-28</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Samuel W. Bridger</u>		<u>Samuel W. Bridger</u>		<u>Bozman Md</u>		<u>5-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 31/1955</u>		<u>BOZMAN CEMETERY</u>		<u>BOZMAN MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>May 30, 1955</u>		<u>Mr. Robert R. Seck</u>		<u>Samuel W. Bridger</u>		<u>St. Michael</u>	

RECEIVED

JUN 6 1955

BUREAU V. S.

4979

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 <u>Easton</u>		24 days		Newcomb			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <u>Memorial Hos.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>M. PARKER H. NEMBLE</u>				OF DEATH: <u>May 24 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>FEB. 15-1872</u>	
9. AGE last birthday: <u>83</u> yrs.		10. AGE last birthday: <u>1</u> year <u>24</u> months <u>0</u> days <u>0</u> hours <u>0</u> min.		11. BIRTHPLACE (State or foreign country): <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Edmund Nemble</u>				14. MOTHER'S MAIDEN NAME: <u>Mary F. A. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mrs. Sally Nemble</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>uncontrollable Epistaxis - undetermined cause</u>						26 days	
ANTECEDENT CAUSE (B) <u>0</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerotic C.V.D.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>cardiac failure - terminal</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>55</u> , to <u>5-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-24</u> , 19 <u>55</u> , and that death occurred at <u>5-48 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Michael J. Michael</u>				ADDRESS <u>St Michaels Md.</u>		DATE SIGNED <u>5-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>May 26, 55</u>		<u>May 26, 55</u>		<u>St Michaels Cemetery</u>		<u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-25-55</u>		<u>N.A. Neer</u>		<u>Charles E. Parker</u>		<u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 2 1935

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04986

4980

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40</u> <u>Easton</u>		LENGTH OF STAY (in this place) <u>21 hrs. 10 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u> <u>05X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna</u> <u>Mezick</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 27 1955</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>1-17-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>N.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Elliott</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Stanford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Mayd Mezick. Preston, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>330X Subarachnoid hemorrhage</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>same as determined</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/26</u> , 19 <u>55</u> , to <u>5/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>55</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Anniston Harrison</u>				DATE SIGNED <u>Caroline Maryland 1 June 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>5-31-55</u>		<u>Leuchaster</u>		<u>Preston Md. - R1</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-28-55</u>		REGISTRAR'S SIGNATURE <u>N.H. Neer</u>		24. GENERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	

RECEIVED

JUN 7 1955

BUREAU V. S.

4981

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40</u> <u>Easton</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> <u>Easton</u> <u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>319 South st.</u>		STREET ADDRESS (If rural give location) <u>319 South st.</u> <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>5</u> <u>30</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11-27-1901</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Roberts</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>215-16-8944</u>	
17. INFORMANT & ADDRESS: <u>Ardea Beth Balto. md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE: <u>420.0</u>		<u>6 months</u>	
ANTECEDENT CAUSE (S):		(A) <u>Arteriosclerotic heart disease with myocardial insufficiency.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>55</u> , to <u>5/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>55</u> , and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>2nd Lt. E. Maron</u>		DATE SIGNED <u>6/2/55</u>	
ADDRESS <u>M. D. 1860 Nova H Easton Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>6/2/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Richards</u>		<u>Easton md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>6/2/55</u>		<u>N.H. Neerux</u>	
FUNERAL DIRECTOR		ADDRESS	
<u>James B. Orrell</u>		<u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04988

4991

## CERTIFICATE OF DEATH

Reg. Dist. No. 290..

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Trappe</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Trappe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2</u>		STREET ADDRESS (If rural give location) <u>Route 2</u>	
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Roberts</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> <u>5</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>1873</u>
9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Bentley</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Bentley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Eddie McDaniel</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>			<u>14 cm</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>54</u> to <u>May 5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May 5</u> , 19 <u>55</u> , and that death occurred at <u>9</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>Edwin Fasset</u>		DATE SIGNED <u>9 May 55</u>	
EDWIN FASSETT, M.D.—227 Pine St—Camb., Md.—9 May 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>5/9/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Trappe Cem</u>		LOCATION (City, town, or county) <u>Trappe Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>M. W. Nevers</u>	
24. FUNERAL DIRECTOR <u>James B. Darbill, Easton, Md.</u>		ADDRESS	

RECEIVED

MAY 16 1955

BUREAU V. S.



4982

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Salisbury</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Queen Anne's</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Queen Anne's</i> 17X-2	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>40 Easton</i>		LENGTH OF STAY (in this place) <i>19d9 14 1/2 hrs</i>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION DR STREET ADDRESS <i>80 Easton Memorial Hosp.</i>							
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <i>Blanche</i> (Middle) <i>Roy</i> (Last)				OF DEATH: <i>5</i> <i>22</i> <i>1955</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>B.</i>	7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>May 15 1911</i>	9. AGE last birthday <i>44</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>HW.</i>				10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME: <i>James Green</i>				14. MOTHER'S MAIDEN NAME: <i>Ran</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>9</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Williams Henry Roy, Rust</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>591X</i>							
ANTECEDENT CAUSE (B) <i>due to</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>and Bronchopneumonia</i>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HDW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/2</i> , 19 <i>55</i> , to <i>5/22</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5/21</i> , 19 <i>55</i> , and that death occurred at <i>12:50</i> A.M., from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS <i>Easton</i>		DATE SIGNED <i>25/9/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>5/25/55</i>		NAME OF CEMETERY DR CREMATORY <i>Chenton</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-23-55</i>				REGISTRAR'S SIGNATURE <i>N.A. Neer</i>		24. FUNERAL DIRECTOR, ADDRESS <i>J.E. Boulain Greensboro, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4983

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04990

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Talbot</b>		MARYLAND		STATE <b>md</b>		COUNTY <b>Talbot</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
40 TOWN <b>Easton</b>		1 day 9 hrs		TOWNSHIP <b>Tnappe</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <b>Memorial Hosp.</b>				/			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <b>May 2, 1955</b>			
5. SEX: <b>M</b>		6. COLOR OR RACE: <b>W</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>M.</b>		8. DATE OF BIRTH: <b>January 6, 1898</b>	
9. AGE last birthday: <b>57</b> yrs.		10. BIRTHPLACE (State or foreign country): <b>Ireland</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Gardner</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>-</b>			
13. FATHER'S NAME: <b>Pat Salmon</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Joyce</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <b>Mrs Mary Salmon (wife) Tnappe Maryland</b>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <b>Myocardial Infarction due to coronary occlusion</b>				3 days			
ANTECEDENT CAUSE (S) (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>2</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5-1-</b> , 19 <b>55</b> , to <b>5-2-</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>5-2-</b> , 19 <b>55</b> , and that death occurred at <b>8:55-P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Donald A. Bartley</b>		M. D. <b>Easton, Md.</b>		DATE SIGNED <b>5-2-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/5/55</b>		NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		LOCATION (City, town, or county) (State) <b>Easton Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5-3-55</b>		REGISTRAR'S SIGNATURE <b>H. H. Newreese</b>		FUNERAL DIRECTOR <b>Mauna E. Newreese</b>		ADDRESS	

BUREAU V. S.

MAY 10 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04991

4984

## CERTIFICATE OF DEATH

Reg. Distr. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Salat</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>440 Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clinton</u> <u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Elizabeth A. Stone</u>		OF DEATH: <u>5</u> <u>27</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>May 1 1883</u>
9. AGE last birthday <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H W.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Adams</u>		14. MOTHER'S MAIDEN NAME: <u>Louella Pettingill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. Parker W. Stone (son)</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>420.1</u>			
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>			
ANTECEDENT CAUSE (S) <u>Myocardial Infarct</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>Coronary occlusion</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>5/15</u> , 19 <u>55</u> , to <u>5/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>55</u> , and that death occurred at <u>3:05 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ed Schmidt</u>		ADDRESS <u>Clinton</u> DATE SIGNED <u>27 May 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 29, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton, Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-28-55</u>		24. FUNERAL DIRECTOR <u>J. Edgar Morrison</u> ADDRESS <u>Denton</u>	

BUREAU V. S.

JUN 7 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04992

## CERTIFICATE OF DEATH

Reg. Dist. No: 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Salisbury</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Caroline</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <i>Embs</i>		6 da.		TOWN <i>Federalburg</i> 05X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <i>Memorial Hospital</i>							
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<i>ELSIE Virginia Thomas</i>		OF DEATH: 5 26 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>W</i>	<i>married</i>	<i>Sept 22, 1877</i>	<i>77</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>StW</i>				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Henry Davis</i>				<i>McChale Lee Thomas (son)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>9</i>				<i>McChale Lee Thomas (son)</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Intestinal Obstruction</i>							
ANTECEDENT CAUSE (S) DUE TO <i>Recurrent Adenocarcinoma of colon</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<i>2</i>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/24</i> , 1955, to <i>5/26</i> , 1955, that I last saw the deceased alive on <i>5/26</i> , 1955, and that death occurred at <i>11:30</i> P. M. from the causes and on the date stated above.							
SIGNATURE <i>Edw. H. H. H. H.</i>		M. D. <i>Boston</i>		DATE SIGNED <i>27 May 1955</i>			
23. BURIAL, CREMATION, REMOVA (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>5/29/55</i>		<i>Stillport Cemetery</i>		<i>Federalburg Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5/27-55</i>		<i>N. H. H. H.</i>		<i>Harry H. H. H.</i>		<i>Federalburg Md.</i>	

BUREAU V. S.

JUN 2 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04993

4986

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <u>Easton</u>		8 da		OR TOWN <u>Easton</u> 40			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <u>Memorial Hospital</u>				246 <u>Glennwood Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lucactia</u>				<u>Thomas</u>			
(Type or Print)				OF DEATH: <u>5</u> <u>19</u> <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>B</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 18 1892</u>	
				9. AGE last birthday: <u>63</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HW</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Samuel Skinner</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>John H. Thomas (same)</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE (A) <u>Chemia</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Chronic glomerulonephritis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 11, 1955</u> , to <u>5/19/55</u> , that I last saw the deceased alive on <u>5/19/55</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>7/3 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/22/55</u>		<u>Richards</u>		<u>Easton</u> <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-20-55</u>		<u>N.H. Neerer</u>		<u>James B. Barthell</u>		<u>Easton, Md.</u>	

BUREAU V. S.

MAY 27 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04994

4987

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 TOWN <i>Easton</i>		1 hr. 40 min		TOWN <i>Federalburg</i> 05X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
80 Memorial Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <i>James Walter Truitt, Jr.</i>				OF DEATH: <i>May 14 1955</i>			
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>July 16, 1904</i>	
				9. AGE last birthday <i>50</i> yrs.		10. IF UNDER 1 YEAR: Mon. Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Wm. C. Truitt</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Hastings</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs. William W. Truitt, Federalburg, Maryland</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <i>Myocardial infarction due to</i>						5 hrs.	
ANTECEDENT CAUSE (S) DUE TO <i>Coronary Occlusion - Acute</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5-14-1955</i> , to <i>5-14-1955</i> , that I last saw the deceased alive on <i>5-14-1955</i> , and that death occurred at <i>12:50 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Donald A. Bartley</i>				ADDRESS <i>Easton, Md.</i>		DATE SIGNED <i>5-14-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>5/15/55</i>		<i>Hill Crest</i>		<i>Federalburg Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>5-15-55</i>		<i>N.A. Neerex</i>		<i>J. Hampton, Jr.</i>		<i>Federalburg</i>	

RECEIVED

MAY 24 1955

BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04995

4988

## CERTIFICATE OF DEATH

Reg. Dist. No. 290..

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Easton</u>		<u>8 days</u>		OR TOWN <u>Federalsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>80 Easton Mem. Hosp.</u>				<u>R.S.P.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Horraine</u>		(Middle)		(Last) <u>Turner</u>		(Month) (Day) (Year)	
(Type or Print)						<u>May 20 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>W.</u>	<u>Married</u>	<u>April 3, 1911</u>	<u>44</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>H.W.</u>						<u>Georgia</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>J. C. Batson</u>				<u>Annie Driver</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9</u>				<u>aged</u>		<u>W. Howard Turner. Same</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) <u>Carcinoma of cervix</u>				
ANTECEDENT CAUSE (S):			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B)				
			DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... , 19..... , to ..... , 19..... , that I last saw the deceased alive on ..... , 19..... , and that death occurred at <u>7:55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Ed Schmidt</u>		M. D. <u>Carroll</u>		DATE SIGNED <u>7/3/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>5/23/1955</u>		<u>St. Vincent Cemetery</u>		<u>Federalsburg, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-21-55</u>		<u>N. H. Neerive</u>		<u>Harry Williams</u>		<u>Federalsburg, Md.</u>	

BUREAU V. 2

MAY 27 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Royal Oak</u>		LENGTH OF STAY (in this place) <u>all life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Royal Oak</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Minnie May Williams</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 5 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 4, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Royal Oak Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Albert Seymour</u>				14. MOTHER'S MAIDEN NAME: <u>Lusy Ann Freeman</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>E. T. Williams, Royal Oak</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE						(A) <u>cerebral thrombosis</u> 10 days	
ANTECEDENT CAUSE (S)						(B) <u>arteriosclerotic cardiovascular</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C) <u></u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>malnutrition &amp; dehydration terminal</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-29</u> , 19 <u>53</u> to <u>5-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James R. Beck</u>		M. D. <u>St. Michaels Md</u>		DATE SIGNED <u>5-6-55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. Polk R. Beck</u>		24. FUNERAL DIRECTOR <u>John D. Williams</u>		ADDRESS <u>Easton, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 10 1955

RECEIVED